

FILED JUL 15 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1003

6115

1. PLACE OF DEATH:

(a) County.....
(b) City or town, St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5331 Maffitt Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... Life (Specify whether
years, months or days)

3. (a) PRINT FULL NAME May E. Cavanaugh

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Dont Know
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Aht. 75 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation none11. Industry or business at home12. Name Daniel J. Cavanaugh

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Julia Dowling

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Dan. V. Cavanaugh
if

(b) Address 5331 Maffitt

17. (a) Burial (b) Date thereof 7/12/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery18. (a) Signature of funeral director Thos. J. Finan(b) Address 1519 S. Grand Ave.

19. (a) JUL 10 1944 J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5331 Maffitt
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1944 hour..... minute..... M.

21. I hereby certify that I attended the deceased from July 9 to July 9, 1944
that I last saw him alive on July 9, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Ac. cardiac dilatation Duration

Due to Chd myocardium
Chd endocardium

Due to Bronchial Asthma
Other conditions See Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....
23. Signature Samuel Way (M. D. or other) no
Address 2906 N. Union Date signed 7/10/44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Howard Ravola

Licensed Embalmer No. *2114*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.